Summary

Health Care Options for California

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The complexity and turbulence of California's health care environment is made more so by seven million uninsured and millions more underinsured. Mechanisms that both mitigate and exacerbate access to care include Medicare and Medicaid, job-based health insurance that covers about two in three working Californians, and the market dominance of managed care organizations on the one hand and huge constellations of providers on the other. Over the years new entitlements have been created and new procedures have been introduced to improve access to care, improve quality of care, protect privacy, and more equitably distribute health care resources. Each category of innovation adds rules and requirements to an already heavily regulated system with hundreds of thousands of payers, providers, and purchasers of care. With the Congress and the President about to agree to new protections for managed care subscribers litigation threatens to add yet further burden.

Earlier this year, the California Health and Human Services Agency undertook an effort to explore options for increasing the number of Californians who are covered by health insurance. As one component of this project, California State University, Northridge, agreed to develop a series of brief papers that would assist policy-makers and the public to understand the complex issues involved in any effort to expand health care coverage. These papers describe the health care marketplace in California and the role of employment-sponsored health insurance. They profile California's uninsured and underinsured populations and explore the unique issues of access to health services for immigrants and the aging population. Finally, there is a paper covering ethical and quality considerations in relating to access to care. Following are highlights of each of these papers. The full papers are available on the Health Care Options Project (HCOP) website. Each paper provides a list of references and recommended readings on the topic covered. The HCOP website also contains a more comprehensive bibliography on health care access issues that was prepared for this project by the California Research Bureau.

The Health Care Market

Governments and private employers purchase health insurance for nearly 80 percent of Americans. Throughout the nation the majority of persons with job-based health insurance and about two in ten elderly with Medicare (50 percent in California) receive health care through thousands of organizations that deliver health care through various kinds of *managed care* arrangements. About 2/3 of Americans have job-based health insurance and millions of early retirees and Medicare beneficiaries continue to look to their former employers for health benefits. Additional millions are Medicare and

Medicaid (Medi-Cal in California) beneficiaries. While most Americans have job-based health insurance or qualify for entitlements, 40-45 million are perennially uninsured and medically indigent. In California 7.3 million are uninsured with several additional million underinsured. Given the exigencies of health need everyone is a potential health care consumer, the availability of health insurance notwithstanding. Persons without health insurance usually delay care as long as possible, self-medicating and hoping for the best. They enter private and public health systems as non-paying but now sicker and more expensive patients. The cost of their uncompensated care adds overhead to the market impacting purchaser, provider, and payer alike.

Almost all California businesses with several hundred or more employees provide for employee health insurance but fewer than half of smaller companies (under fifty employees) do so. Working persons make up eight in ten of the uninsured. California ranks last among the states in the number of persons with job-based health insurance. The Californians least likely to have health insurance are low wage earners, Latino males, young adults, non-citizens, and working women.

Employer Sponsored Insurance and the Uninsured in California

National health expenditures in the United States as a proportion of the gross domestic product (GDP) are a long time concern. In the early 1990s, the expectation was that health expenditures would reach 18 percent of the GDP within the decade. This troubling forecast alarmed government and employers alike. The prospect of escalating insurance premiums seemed to foreshadow a cost-doomed end to employment-based health insurance. Premiums were rising much faster than the rate of inflation. These cost increases prompted a shift away from traditional fee-for-service insurance programs toward managed care arrangements that slowed cost growth. Further reductions in health expenditures were accomplished through the Balanced Budget Act. As a result, the level of national health expenditures stabilized at about 13 percent of GDP. However, estimates from the Health Care Financing Administration predict that national health expenditures will approach 16 percent of GDP by 2010.

Although California resembles the rest of the country in the number of large, medium, and small employers, and in the rate at which people qualify for and accept employer-sponsored insurance, growth in the number of uninsured Californians was higher than the growth on average in the rest of the country. In 1999, 22 percent of individuals under age 65 in California were uninsured, which compares to only 17 percent on average for the rest of the country. Several factors contribute to this difference. California's larger employers are more likely to offer employer-sponsored insurance than smaller employers are. White-collar businesses such as finance or professional service are also more likely to offer insurance benefits than companies in construction and agriculture. Low wage earners are less likely to be offered or to obtain insurance. Additionally, Latinos are less likely to be insured and non-citizen Latinos are much less likely to be insured than people from other races or ethnicities are.

Profile of the Uninsured in California

More people are becoming aware of the number of medically uninsured and the implications the uninsured population has for health care affordability and quality. Recent surveys indicate that Californians are willing to pay additional taxes to assure that all families and children have access to affordable health insurance. Current estimates are that 22 percent of the state's population is uninsured. Without insurance they have limited access to medical care and either forgo or delay treatment because of the out-of-pocket cost. Many of the uninsured access care through safety net providers – community clinics, county clinics or hospitals -- or through hospital emergency departments. The uninsured are a continual financial drain to hospitals throughout California, most of which operate on very thin profit margins.

Many people believe the uninsured are also the unemployed. This misconception masks the fact that eight out of ten uninsured are employed. Latinos and young adults make up the largest proportion of the uninsured although the uninsured include persons of every socio-economic strata. Persons are uninsured for many different reasons. Some work for employers that choose not to provide job-based health insurance. Other employees do not meet eligibility criteria for job-based coverage. Some are unemployed, do not have access to affordable group coverage, and are ineligible for public insurance programs. Some persons are employed in low-income jobs and are unable to afford the out-of-pocket costs of group or individual coverage. Those with chronic or pre-existing health conditions can find that private insurance is unaffordable. Experience, cultural, and language barriers, lack of literacy in English or their language of origin, and fear of immigration or other government authority also create an array of barriers to health insurance for many immigrants. For those potentially eligible for public insurance, bureaucratic processes can be confusing and intimidating. These procedures too often serve to dissuade rather than encourage enrollment. Potential solutions for reducing the number of uninsured in California include: (1) employer and individual tax credits tied to purchase of health insurance, (2) subsidized insurance coverage for small businesses, (3) streamlined and uniform eligibility and enrollment processes across all public insurance programs, (4) expanded eligibility limits for public health insurance programs, (5) use of the single payer model, and (6) enhanced outreach efforts to identify and link the uninsured with available resources. The magnitude of the uninsured issue in California will require the application of multiple interventions. Local programs targeting the uninsured as well as programs developed in other states may serve as models for California in expanding health coverage for the uninsured populous.

Access to Health Care for California's Immigrants

The working poor and indigent members of California's diverse immigrant communities face formidable barriers to care. The increased federal role in welfare and child health insurance reform has led California to re-evaluate safety net policies and to experiment broadly in health and welfare reform. While California is seeking to increase the number of insured families through the expansion of Medi-Cal and Healthy Families programs, a consistently large number of immigrants statewide remain uninsured. With confusing information about welfare reform, thousands of legal immigrants have not sought public benefits, even though they remain eligible for a variety of programs, because they believe

that accepting these benefits could affect their immigration status. Effective outreach to California's immigrant families requires culturally appropriate messages and styles of communication using familiar elements of an immigrant group's "ethnic culture."

Coverage and Access to Care for Older Californians

The population of California is aging rapidly in what has been described as the "graying of the Golden State." Currently an estimated 3.6 million Californians (11 percent of the total state population) are ages 65 or older, but the older population will more than double by 2030 to 8.9 million (17 percent). The fastest growing age group is the "very old", those age 85 and over, who will increase nearly fourfold in numbers from 450,000 in 2000 to 1.7 million by 2040. The aging of the population in California will have major impact on health care costs as well as the health care system.

Most Californians ages 65 and over have the advantage of Medicare coverage. Yet, the elderly remain disadvantaged because they lack comprehensive health benefits and lack access to affordable coverage for long-term care. These gaps in health care coverage leave seniors unprotected against high out-of-pocket costs and at-risk for catastrophic costs in the event that long-term care is needed. Gaps in insurance coverage affect seniors by imposing burdensome financial liabilities in several areas of health care services such as pharmaceutical costs and long-term care. Several options for controlling costs and expanding coverage to ensure the adequacy, affordability, and accessibility of health care for older Californians should be considered.

Quality and Equity Concerns in Health Insurance Coverage/Non-Coverage

Equity is not the same as equal; however, systems of health care rarely acknowledge the impossibility of achieving equal health status for all. Much ill health is due to social circumstances including poverty, poor housing, inadequate nutrition, inappropriate health behavior, and lack of preventive and primary care. Systems of care, including third party payer-fostered systems, must distinguish between medical, social, and psychological need. Good health care contributes to health and good health is a precondition to quality of life. Health care also provides essential caring and validation functions.

Persons are more effective participants in society when they are in good health and can access quality care. If utilization of health care is not significantly associated with better outcomes, a major component for consideration may be the quality of care. Both equity and quality depend on providing arrangements that foster ethical gate-keeping and respectful, appropriate care, address social as well as individual needs, and reward correct incentives. Other essential considerations include an integrated system with decentralized service, benefits standards, and rational staffing and delivery. Unfortunately the data about causes of disparities in access, outcomes, and health care quality are inadequate. Ongoing data assessment is necessary to develop short and long-range strategies.

Quality and equity require financially neutral decision-making at the bedside. Difficult rationing decisions should not be made at the bedside. Extensive public discussion, education and conversation with patients, and policies regarding standards of appropriate care must be developed and supported well in advance of bedside decision-making. Given the problematic

relationship between health care and health, justice requires consideration of alternative spending on other needs. The allocation of public health measures that reach larger groups and improve health in the longer term should also be re-evaluated. Such measures are critical to equity and quality in a system of universal care.

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